

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/28/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>15G736</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/22/2012</b>	
NAME OF PROVIDER OR SUPPLIER  <b>ABILITIES SERVICES INC</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 S EARL AVE</b> <b>LAFAYETTE, IN 47905</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{W 000}	<p><b>INITIAL COMMENTS</b></p> <p>This visit was a post-certification revisit (PCR) to the PCR conducted on 02/15/12 to the full recertification and state licensure survey conducted on January 10, 2012.</p> <p>This visit was in conjunction with the PCR to the PCR completed on 02/15/12 to the PCR completed on 01/10/12, to the PCR completed 08/04/11, to the investigation of complaint #IN00092167 completed on 7/1/11.</p> <p>This visit was in conjunction with the PCR to the PCR completed on 02/15/12 to the PCR completed on 01/10/12, to the PCR completed 08/04/11, to the investigation of complaints #IN00089801 and #IN00090212 completed on 5/6/11.</p> <p>This visit was in conjunction with the investigation of complaint #IN00104280.</p> <p>Dates of Survey: March 21 and 22, 2012.</p> <p>Facility number: 005592 Provider number: 15G736 AIM number: 200859130</p> <p>Surveyor: Claudia Ramirez, RN, Public Health Nurse Surveyor III</p> <p>Abilities Services Inc. was found to be in compliance with 42 CFR, part 483, subpart I, and 460 IAC 9 in regard to the PCR to the PCR to the full recertification and state licensure survey. Quality Review completed 3/27/12 by Ruth Shackelford, Medical Surveyor III.</p>			{W 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.